

**New Jersey Department of Health and Senior Services
SALMONELLA / STEC (INCLUDING *E. coli* O157:H7) QUESTIONNAIRE**

Interviewer		CDRSS Case ID No.
Agency	Date	NJ Isolate #

I. DEMOGRAPHICS		
Name (Last, First)	Date of Birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Parent's Name (if child)		Telephone

II. ILLNESS HISTORY	
Date of onset of illness: ____/____/____ Time: ____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM Nausea..... <input type="checkbox"/> Yes <input type="checkbox"/> No Diarrhea..... <input type="checkbox"/> Yes <input type="checkbox"/> No Onset: ____/____/____ <input type="checkbox"/> AM <input type="checkbox"/> PM Maximum number of stools in 24 hour period: ____ Duration (days): ____ Blood in Stool..... <input type="checkbox"/> Yes <input type="checkbox"/> No Vomiting..... <input type="checkbox"/> Yes <input type="checkbox"/> No Cramps..... <input type="checkbox"/> Yes <input type="checkbox"/> No Headache..... <input type="checkbox"/> Yes <input type="checkbox"/> No Fever..... <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, highest temp recorded ____° Were you treated with antibiotics for this illness? <input type="checkbox"/> Yes <input type="checkbox"/> No Antibiotics: _____ Were you hospitalized overnight because of this illness? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, hospital name: _____ Admit Date: ____/____/____ Discharge: ____/____/____ Do you know of anyone else who has had these symptoms during the week before or after you became ill? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, who? Name: _____ Phone: _____ Name: _____ Phone: _____	

III. OPEN ENDED FOOD HISTORY			
Please try to remember what you may have eaten in the 5-day period before you started feeling sick: (____/____/____ to ____/____/____) We will start with the day (or day before) you got sick and work backwards. (If a meal was eaten out, specify where.)			
Day 1 (____/____/____)			
Breakfast <input type="checkbox"/> Home or <input type="checkbox"/> Out: _____ _____ _____ _____	Lunch <input type="checkbox"/> Home or <input type="checkbox"/> Out: _____ _____ _____ _____	Dinner <input type="checkbox"/> Home or <input type="checkbox"/> Out: _____ _____ _____ _____	Other/Snacks _____ _____ _____ _____

SALMONELLA / STEC (INCLUDING *E. Coli* 0157:H7) QUESTIONNAIRE

NJ Isolate No.

CDRSS Case ID No.

III. OPEN ENDED FOOD HISTORY, CONTINUED

Day 2 (_____, ____ / ____ / ____)

Breakfast

☐ Home or
☐ Out:

Lunch

☐ Home or
☐ Out:

Dinner

☐ Home or
☐ Out:

Other/Snacks

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Day 3 (_____, ____ / ____ / ____)

Breakfast

☐ Home or
☐ Out:

Lunch

☐ Home or
☐ Out:

Dinner

☐ Home or
☐ Out:

Other/Snacks

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Day 4 (_____, ____ / ____ / ____)

Breakfast

☐ Home or
☐ Out:

Lunch

☐ Home or
☐ Out:

Dinner

☐ Home or
☐ Out:

Other/Snacks

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Day 5 (_____, ____ / ____ / ____)

Breakfast

☐ Home or
☐ Out:

Lunch

☐ Home or
☐ Out:

Dinner

☐ Home or
☐ Out:

Other/Snacks

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

IV. RESTAURANTS AND GROCERY STORES

Did you eat out at any restaurants (including fast food restaurants, delis, and take-out or home delivery meals) during the 5 days before your illness? ☐ Yes ☐ No *If Yes, list names and locations of restaurants.*

Name: _____	Location: _____
Name: _____	Location: _____
Name: _____	Location: _____
Name: _____	Location: _____

Where did you purchase groceries that were eaten during the 5 days before your illness (including specialty stores, produce or fruit stands, dairy marts, etc.)?

Name: _____	Location: _____
Name: _____	Location: _____
Name: _____	Location: _____

SALMONELLA / STEC (INCLUDING *E. Coli* 0157:H7) QUESTIONNAIRE

NJ Isolate No.

CDRSS Case ID No.

V. DETAILED FOOD HISTORY

Now, I would like to ask you about specific food items. During the 5 days before you got sick, did you eat the following items?

A. Dairy Products

Eggs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Unpasteurized Milk	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Cottage Cheese	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Cream Cheese	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Farmer's Cheese	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Ricotta Cheese	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Deli Cheeses	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Other Cheeses	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Ice Cream	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Yogurt	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS

Comments (variety/brand, how prepared, where bought/eaten, etc.)

How prepared? _____

Sliced or prepackaged? _____

Specify: _____

B. Poultry, Meats and Fish

Chicken	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Turkey	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Sausage	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Ham	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Pork	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Hot Dog	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Hamburger	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Other Ground Beef	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Steak	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Deli Meats	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Fish	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Shellfish (e.g. shrimp, lobster, clams, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Other Poultry/Meat/Fish	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS

Specify: _____

Specify: _____

Specify: _____

Specify: _____

Specify: _____

Specify: _____

C. Fresh/Uncooked Salads and Vegetables

Pasta Salad	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Potato Salad	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Seafood Salad	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Cole Slaw	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Prepackaged or Prebagged Salad	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Caesar Salad	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
<i>Lettuce (non-bagged, whole heads or lose leaf)</i>			
Iceberg	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Green Leaf	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Romaine	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Red Leaf	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Mesclun	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Alfalfa Sprouts	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Other Sprouts	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Spinach	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Cabbage	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Tomatoes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Carrots	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Broccoli	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Cucumbers	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS

Specify type

or mix/brand: _____

Specify type (cherry, plum, etc.): _____

SALMONELLA / STEC (INCLUDING *E. Coli* 0157:H7) QUESTIONNAIRE

NJ Isolate No.

CDRSS Case ID No.

Celery	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Mushrooms	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Peppers	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Onions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Scallions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Parsley	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Cilantro	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Basil	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Other Vegetables	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS

D. Fruits

Watermelon	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Cantaloupe	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Honeydew Melon	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Oranges	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Grapefruit	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Pears	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Apples	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Grapes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Bananas	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Strawberries	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Raspberries	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Blueberries	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Other Berries	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Kiwi	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Mango	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Pineapple	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Avocado	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Other Fruits	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS

Red or green? _____

E. Unpasteurized Juices

Apple Cider	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Orange Juice	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Other Juices (e.g., smoothies)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS

F. Dessert Novelties

Cake	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Pies	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Pastries	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS
Uncooked Dough or Batters	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK/NS

VI. OTHER EXPOSURES (TRAVEL, SWIMMING, CONTACT WITH ANIMALS)

Did you travel out of the country? ☐Yes ☐No Where/Dates: _____

Did you travel to any other state(s)? ☐Yes ☐No Where/Dates: _____

Did you do any swimming or wading? ☐Yes ☐No Where/Dates: _____

Did you attend any large gatherings (parties, festivals, fairs, etc.)? ☐Yes ☐No

If yes, where/dates/foods: _____

Did you have any direct contact with any farm animals? ☐Yes ☐No _____

Did you visit a farm with animals or a petting zoo? ☐Yes ☐No _____

Did you have contact with reptiles (snakes, lizards, turtles)? ☐Yes ☐No _____

SALMONELLA / STEC (INCLUDING *E. Coli* 0157:H7) QUESTIONNAIRE

NJ Isolate No.

CDRSS Case ID No.

Do you have household pets?

☐ Yes ☐ No

Type: _____

Did you have contact with household pets outside your home? ☐ Yes ☐ No

Type: _____

VII. HIGH RISK OCCUPATIONS OR ACTIVITIES

What is your occupation? _____

Do you handle or prepare food as part of your duties at work or as a volunteer? ☐ Yes ☐ No

If yes, location: _____

Did you provide health care? ☐ Yes ☐ No

If yes, location: _____

Provide *DIRECT* patient care? ☐ Yes ☐ No

Do you attend or work in a day care setting? ☐ Yes ☐ No

If yes, location: _____

Are you aware of any other illness in the daycare? ☐ Yes ☐ No

VIII. RACE/ETHNICITY

What is your race?

☐ White ☐ Asian, Pacific Islander ☐ Black ☐ American Indian ☐ Other, Specify: _____

☐ Don't Know ☐ Refused

Are you of Hispanic origin?

☐ Yes ☐ No ☐ Don't Know ☐ Refused

IX. COMMENTS

Please complete and return via fax to 609-631-6496.